THE EVALUATION OF COMPREHENSIVE COMMUNITY SERVICES

by

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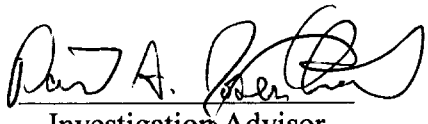

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ABSTRACT

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The Evaluation of Comprehensive Community Services

Guidance and Counseling David Rosenthal, Ph.D. May, 2000 88 pages

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FIVE COMMUNITY BASED MENTAL HEALTH PROGRAMS, CERTIFIED BY THE WISCONSIN DEPARTMENT OF HEALTH AND SOCIAL SERVICES, WERE IDENTIFIED AND ANALYZED. A QUALITATIVE METHOD WAS USED IN THIS STUDY. THE OBJECTIVES OF THIS STUDY INCLUDED: TO REVIEW LITERATURE FOR PERTINENT INFORMATION ABOUT THE EVALUATION OF COMMUNITY BASED MENTAL HEALTH OUTPATIENT PROGRAMS; TO OBTAIN EVALUATION PLANS FROM A SAMPLE OF CERTIFIED PROGRAMS; TO EXAMINE PLANS OBTAINED FOR UNIQUENESS, SIMILARITIES AND DIFFERENCES AND TO DEVELOP AN EVALUATION PLAN WHICH COULD BECOME INTEGRATED INTO THE COMPREHENSIVE COMMUNITY SERVICES PROGRAM LOCATED IN MARATHON COUNTY, WISCONSIN.

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This research is dedicated to the Mental Health Outreach Program, located in Wausau, Wisconsin.

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Chapter I

INTRODUCTION

STATEMENT OF THE PROBLEM

Studies have shown that community based mental health programs are more effective in treating individuals who have a mental illness than traditional forms of aftercare. Yet, almost no systematic empirical knowledge exists about their actual implementation, including the kinds of treatment they deliver, how they can be replicated, or what ingredients account for their success. Developing effective community based mental health programs requires making a commitment to the evaluation of programs as they are implemented. Without monitoring a program's implementation, there is no evidence that the treatment provided by the program was delivered as intended and no information about how to replicate the program (Brekke, 1988).

Most programs have some type of evaluation plan to attempt to determine their effectiveness. In 1989, the Wisconsin Administrative Code for community support programs included evaluation criteria, but the importance of such evaluations has begun to receive attention only in the past year.

The Mental Health Outreach Program (MHO), located in Marathon County, Wisconsin is seeking certification through

the Wisconsin Department of Health and Social Services. Upon certification this program will be called, Comprehensive Community Services (CCS). Programs that are applying for certification are required to have an evaluation plan in place as part of their program policies and procedures. It is the intent of this study to develop an evaluation plan which will ascertain the quality and effectiveness of the MHO Program located in Marathon County, Wisconsin.

PURPOSE AND OBJECTIVES

The purpose of this study is to investigate emerging beliefs and practices about evaluating community based mental health programs that have been certified by the Wisconsin Department of Health and Social Services. Specific objectives include:

1. To review literature for pertinent information about the evaluation of community based mental health programs.
2. To obtain copies of evaluation plans from several certified community based mental health programs.
3. To examine plans received from other certified community based mental health programs for uniqueness, similarities and differences.
4. To develop an evaluation plan that will become integrated into the MHO Program located in Marathon

County, Wisconsin.

THE ASSUMPTIONS

1. Community based mental health programs vary in the amount and types of services provided.

2. Without high quality program monitoring, community based mental health programs are at risk of a reduction in state and federal funding.

THE DEFINITION OF TERMS

The following definitions have been taken from:

Wisconsin Administrative Code
Department of Health and Social Services
Comprehensive Community Services
Draft(March,2000)

1. Assessment - the process used to evaluate a client's presenting problems with an accompanying description of the reported or observed conditions which led to the classification or diagnosis of the client's mental illness.

2. Case management - an organized process for providing a full range of appropriate treatment, rehabilitation and support services to a client in a planned, coordinated, efficient and effective manner.

3. Certification - the approval of a Comprehensive Community Services Program by the department of Health and Social Services.

4. Severe mental illness - a mental illness which is severe

in degree and persistent in duration, which causes a substantially diminished level of functioning in the primary aspects of daily living and inability to cope with the ordinary demands of life, which may lead to an inability to maintain stable adjustment and independent functioning without long-term treatment and support and which may be of lifelong duration.

5. Client - an individual who has completed the admissions process under the Wisconsin Administrative Code and is receiving treatment or services for mental illness.

6. Comprehensive Community Services - a coordinated care and treatment program which provides a range of treatment, rehabilitation and support services through an identified treatment program and staff to ensure ongoing therapeutic involvement, individualized treatment, rehabilitation and support services in the community for persons with chronic mental illness.

7. Supervision - intermittent face-to-face contact between a supervisor and a staff member to review the work of the staff member.

Chapter II

THE REVIEW OF RELATED LITERATURE

The purpose of this study is to investigate emerging beliefs and practices regarding the evaluation of community based mental health programs that have been certified by the Wisconsin Department of Health and Social Services, and to subsequently develop an evaluation plan that will become integrated into the MHO program located in Marathon County, Wisconsin.

In this review of literature the following major dimensions will be reviewed: client characteristics, services provided, frequency and duration of contacts, service delivery, staffing patterns and operations, continuity of care, and funding.

Brekke and Test (1987) state, "Without monitoring a program's implementation, we have no evidence that the treatment the program provided was delivered as intended and no information about how to replicate the program" (p. 51). The monitoring evaluation identifies the services the program delivers and explores whether the program reaches the intended population and whether services are delivered in a way they were intended to be (Brekke & Test, 1987).

Monitoring makes it possible to study the crucial

ingredients of a model, and also allows comparison of various community based mental health programs with the aim of eventually understanding what kinds of programs or program elements are beneficial to which clients.

Client Characteristics

The Mental Health Outreach Program is an outpatient program serving clients 18 years of age and older with a serious mental illness. The clients have been diagnosed by a psychiatrist as having a severe mental illness as listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, commonly referred to as DSM-IV, and meeting the Wisconsin Administrative Code (Draft-2000) designed for Comprehensive Community Services Programs for chronically mentally ill persons.

Some MHO clients are committed to the Community Services Board for treatment of their mental illness and a majority of MHO clients are treated with psychotropic medications.

Since the eventual aim of research on community based mental health programs is to determine what kinds of services are most useful for what kinds of clients, it is essential to describe in an analysis the kinds of clients a given program serves (Brekke & Test, 1992). Minimally, it would be useful to characterize clients on basic demographic indices such as

age, gender, ethnic group, marital status, and on indicators of psychiatric and functional status such as diagnosis, duration of illness, and current and prior functioning in the domains of symptomatology, hospitalization, work, and social functioning (Brekke & Test 1992).

Clients who lack resources, especially the financial or social-support resources necessary to manage traveling around town, are more inclined to call upon case managers than are clients with ample resources of this type. Family members can serve as "someone to talk to" and preclude the need for a client to call a case manager for informal counseling. Thus, according to Grusky (1987), socially isolated clients are more frequent users of case management services.

Services Provided

There is agreement in the field that an ideal service system should assist clients in most areas of daily living (Turner & TenHoor 1978). Potential areas of service provision include the following: vocational, residential, medication, social and recreational, psychotherapy, interpersonal support, activities of daily living, crisis stabilization, general medical, help with substance abuse, assistance in applying for entitlements, protection of client rights, case management, advocacy and linkage, and support

and education to family, friends, and community members (Brekke & Test 1992).

According to Burke (1992), several community based mental health services are currently being offered, including: assessment, screening, treatment plan development, case management, medication therapy, nursing services, crisis intervention, support to client, family and significant others, resource development, coordination of services with other agencies, training in activities or daily living, vocational rehabilitation, money management and emergency funding. These services are made available to clients with the goal of maintaining adequate adjustment to the community, developing individual potential and rehabilitation, and to develop a coordinated network of agencies and individuals responsive to the client's needs (Burke, 1992).

Community based mental health programs vary greatly in the type and frequency of the services provided. Available community resources and staff to client ratio are typical indicators of what type of services will be offered and how often contacts will be made between clients and staff (Dowell & Ciarlo, 1983).

Frequency and Duration of Contacts

Brekke and Test (1992) report the following:

The amount of contact that clients receive from staff is a critical dimension on which programs vary, and can be measured as both the frequency and duration of contact. If the frequency and duration of service provision are measured over an extended period of time, the pattern of service provision can also be ascertained(pg. 230. Stein and Test (1985), confirm Brekke and Test's ideas by suggesting that, for some clients, treatment and support may need to be considered on an ongoing and long term basis, rather than time limited. As a result, it is important to measure the length of time that services are provided (Stein & Test, 1985). Providing the proper frequency of service along with the locus of service delivery are fundamental aspects of community based mental health programs.

Service Delivery

According to Brekke (1988), the majority of services provided by community based mental health programs should be delivered in the community. Burke (1992), expands on this approach and claims that if program services are brought to the client, the need to generalize skills learned in the treatment setting to the community at large, will be minimized.

Community based mental health programs vary significantly

in the locus of treatment, therefore, it is critical to measure the number of contacts with clients that take place at the program site, in the community and on the telephone (Brekke & Test, 1992). An adequate composition and quantity of staff are both essential in providing treatment services in a variety of settings (Grusky et al., 1987).

Staffing Patterns and Operations

Brekke (1988) refers to the importance of engaging and maintaining staff's high-quality participation in the effort to collect data to allow for accurate program evaluation. In most cases, program monitoring requires the involvement of front-line program staff (Brekke, 1988). In community based mental health programs, this would be the case managers. On the other hand, Lebow (1987), reports that it is best to employ someone other than the service provider in data collection to minimize bias. Involving the care provider increases the level of compliance, but may also increase the potential for bias.

An adequate program description includes the number of staff, staff-to-client ratio and the composition of staff. Role diffusion, staff morale, team orientation, and how rigidly the daily structure of program services are adhered to may also contribute to the competency of a CSP (Brekke &

Test, 1989).

Wisconsin Administration Code (Draft - 2000) requires that a CCS shall employ a director, who has overall responsibility of the program, a psychiatrist, to provide psychiatric services, and a clinical coordinator, to have responsibility for and provide direct supervision of the CCS's client treatment services and supervision of CCS clinical staff. This code also requires that CCS's employ CCS professionals, commonly referred to as case managers. The ratio of client-to-case manager may not exceed twenty clients to one full-time equivalent case manager without state approval. This ratio is an important aspect to consider when evaluating the provision of continuous care and emphasizing a holistic approach in treatment.

Continuity of Care

The necessity to provide continuity of care is repeatedly brought to attention in literature regarding community based mental health programs (Brekke & Test, 1992). To assess the continuity of care sufficiently, the implementation of the entire system of care, as it relates to the client, needs to be addressed. The extent to which the program is comprehensive as well as the amount of advocacy and linkage services which it provides are relevant program

dimensions (Brekke & Test, 1992).

Dowell and Ciarlo (1983) indicate the importance of providing a comprehensive service system, facilitating the delivery of whichever type of treatment is needed by a particular client. They indicate that many cases are not referred for services due to the lack of appropriate resources. Pardes and Stockdill (1983) also bring to attention the crucial element of undeveloped resources due to funding issues.

Funding

Community based mental health programs seem to offer the possibility of improving cost effectiveness at the same time as improving the quality of life of participants in the program (McClary et al., 1989). Most programs, including CCS, involving public monies are required to perform some type of effectiveness evaluation (Owen, 1984). As states spend millions of tax dollars to provide mental health services to individuals, it has become increasingly important that agencies have data to support how well programs are accomplishing their objectives. Without information about the effectiveness of services, program funding decisions are ultimately based on cost factors or service activity independently (Lemoine & Carney, 1984).

Summary

Funding shifts in the nation's mental health system have been a concern for the past several years and continue to be a concern for mental health programs. As a result of this, it is important for the Marathon County - Comprehensive Community Services Program, to develop an effective evaluation plan for monitoring and improving upon the quality and appropriateness of care provided to clients.

Chapter III.

RESEARCH METHODOLOGY

The purpose of this study was to investigate emerging beliefs and practices about evaluating community based mental health program's, that have been certified by the Wisconsin Department of Health and Social Services in general, and develop an evaluation plan for use in Marathon County, in particular. A qualitative method was used in this study employing aspects of a case study.

The qualitative design is the most appropriate for this research because the goal was to obtain a holistic view of the services provided by certified mental health programs, located in Wisconsin. Borg and Gall (1993) state, "Qualitative researchers seek to understand a complex phenomenon by examining it in its totality, in context" (p.198). Qualitative research originates from the social sciences. Social sciences, in turn, are interested in the study of human behavior (Borg & Gall, 1993). Community based mental health programs are also concerned with human behavior and impaired functioning in this area, which is another reason the qualitative method is suitable for this study.

This study was developed in several steps. First, literature was reviewed for pertinent information about the

evaluation of community based mental health programs. After reviewing this literature, the Bureau of Community Mental Health was contacted in order to obtain a current listing (Appendix A), of community based mental health programs that were certified in Wisconsin.

Twenty percent of the certified programs were randomly selected to be included in this study. The directors of each of these programs were contacted with the request for submission of a copy of the evaluation plan that was being used by their agency.

Seven of the plans that were requested were received, (see Appendices B through F - two are not included due to client names being listed and confidentiality). A follow up request was made by telephone, which did not improve the response rate. Of the seven plans received, two were incomplete, therefore excluded from this study. Upon receipt of the plans, they were reviewed for uniqueness, similarities and differences.

After reviewing these five evaluation plans, the development of this study's evaluation plan occurred.

Chapter IV

RESULTS

The purpose of this research was to investigate emerging beliefs and practices regarding evaluating community based mental health programs that have been certified by the Wisconsin Department of Health and Social Services. The objectives of this study were to review literature for pertinent information about the evaluation of community based mental health programs; examine plans received from other community based mental health programs for uniqueness, similarities and differences; and develop an evaluation plan which could become integrated into the CCS located in Marathon County, Wisconsin. The results of each objective will be presented below on an individual basis.

Objective 1: **To review literature for pertinent information about the evaluation of community based mental health programs.**

Literature reviewed on the evaluation of community based mental health programs encompassed the dates from 1978 to 1999, with primarily utilizing research conducted by Brekke and Test (1987 - 1982). The literature reviewed contained models for evaluating community based mental health programs and the methodological issues involved.

The models contained in the literature addressed elements of program implementation considered most useful to measure. These elements included: client characteristics, services provided, frequency and duration of contacts by staff, location of service delivery, staffing patterns and operations, continuity of care and funding.

Determining what a program actually provides to its clients and assessing how the program operates allows study of whether services are delivered. according to the programs objectives (Brekke & Test, 1987). Brekke (1988) elaborates on this by concluding that the methods used to monitor a program must provide data that can help not only in the understanding of the program, but in replicating it as well.

Objective 2: **To contact other community based mental health programs located in Wisconsin, that are certified, in order to obtain the evaluation plans used by their programs.**

Contact was made with the Bureau of Community Mental Health to obtain a current listing of certified, community based mental health programs (see Appendix A). At the time of this research, forty-seven certified community based mental health programs existed in Wisconsin. Twenty percent of these programs were randomly selected to be included in this study. The directors of each of these programs were

contacted with the request for submission of a copy of their program's current evaluation plan. Of the nine programs contacted, one-hundred percent verbally agreed to forward copies of their current evaluation plan, although only seventy-eight percent followed through. Another twenty-two percent of the plans were not complete, therefore unusable, resulting in a fifty-six percent compliance rate.

Objective 3: **To examine plans received from other certified community based mental health programs for uniqueness, similarities and differences.**

Evaluation plans from the following certified programs were used in this study: Douglas County, Green County, Marathon County, Monroe County and Sawyer County. All programs are Community Support Programs (CSP), (see Appendices B through F). The five plans were reviewed for uniqueness, similarities and differences. A combined total of twenty-four aspects of care were identified for data collection in these programs. Each program varied in the aspects chosen to evaluate, with Marathon County evaluating the broadest number, nineteen or seventy-nine percent of all aspects being evaluated by Marathon County CSP. One aspect of care, meeting treatment plan goals as established in each client's individual treatment plan, was being considered by

all five of the programs in this study.

Eighty percent of the programs identify employment and medication compliance as aspects to evaluate and sixty percent of the programs have selected psychiatric hospitalizations to collect data on for the purpose of evaluation. Other aspects of care identified were: maintaining client's in the least restrictive setting, independence in homemaking skills, reducing legal constraints, Alcohol and Drug related hospitalizations, legal altercations within the community, medication education and evaluation, location of service contacts, independence in obtaining transportation, compliance with the development of treatment plans within thirty days of a client's admission to the CSP, groups offered by the CSP, client satisfaction, family satisfaction, staff cohesion and morale, charts being reviewed for program components, community education, symptom monitoring, social functioning, crises intervention, client rights and self-care.

Objective 4: **To develop an evaluation plan that could become integrated into the Comprehensive Community Services Program located in Marathon County, Wisconsin.**

This study resulted in the development of an evaluation plan that will be utilized by the Marathon County

Comprehensive Community Services Program, located in Wausau, Wisconsin (see Appendix G). The aspects of care identified as most appropriate to evaluate for this study are described and analyzed below. These aspects of care were selected to be included in the evaluation plan as they occur frequently, are high-risk factors or have produced problems in the past for clients or staff. These aspects of care are: 1) The number of psychiatric hospitalizations; 2) Vocational services and employment; 3) Locus of service delivery; 4) Medication compliance; 5) Legal constraints on clients; 6) Client living situations and 7) Targeted short and long term treatment goals as identified in each client's individual treatment plan.

Minimize Hospitalizations

It was found through studying the different evaluation plans received, that a focus of community based mental health programs is to limit the frequency and duration of inpatient psychiatric treatment. The number of overnights spent in psychiatric hospitals annually and the number of clients hospitalized annually for psychiatric treatment were recorded in the plans reviewed. Although a goal of treatment is to minimize hospitalizations, research indicates that there are times when hospitalization is necessary. Precipitants for

hospitalizations are an area addressed in the plans reviewed. Also included are the type of hospitalization that occurs, such as; psychiatric, alcohol or other drug abuse related or a combination of the two.

The duration of inpatient treatment was noted in the plans reviewed. Justification for addressing duration was, not only due to the impact that it causes disruption within the family, work, etc., but it is an indicator of how effective providers are in identifying symptoms and providing intervention before a client becomes so acute that an extended length of stay in the hospital is necessary for stabilization. Medical Assistance, along with other insurance providers require that each client's treatment plan must reflect the frequency of contacts by case managers, therapists, psychiatrists, and other significant providers to obtain reimbursement for these services. The frequency of these contacts changes as client needs arise. The frequency listed on the treatment plan has been deemed appropriate by the client, case manager, clinical coordinator, program director and psychiatrist. Monitoring of psychiatric symptoms is a primary reason that case managers make visits to clients.

The number of clients hospitalized annually for

psychiatric treatment was also important to note. It was recognized by the programs studied that if only the number of inpatient days were accounted for, the statistics could be very misleading due to certain clients that are repetitively hospitalized, or are inpatient on an ongoing basis, while others are maintained in the community without any hospitalizations. In this case one or two clients could account for the majority of days that an entire community support program has recorded for the year.

Increase Vocational Services and Employment

The different evaluation plans examined, included variables such as competitive employment, sheltered employment, supported employment, volunteer roles or vocational training. The structuring of time, enhancement of self-esteem and improvement of financial resources were issues mentioned in the plans reviewed as significant in regards to vocational services and employment.

The Wisconsin Department of Health and Social Services requires that CCS's provide or make arrangements for the provision of rehabilitation services including employment related services.

Monitor The Locus of Service Delivery

Location of contacts made by staff to clients is an

aspect of care that the Department of Health and Social Services requires monitoring, although only one of the programs involved in this research is currently doing so. A goal of providing over fifty percent of service contacts in the community, in non-office based or non-facility based setting is also required (Wisconsin Administrative Code, Draft - 2000). Bringing services to the client was noted by Burke (1992) to minimize the need to generalize skills learned in the treatment setting to the community at large.

Monitor Medication Compliance

Burke (1992) reports that the majority of mental health consumers take psychotropic medications. Evaluation plans reviewed reflect the importance of medication monitoring for compliance, side effects, education, and therapeutic dosages.

Minimize legal constraints

Legal constraints documented in the plans reviewed included mental health commitments, guardianships, protective placements and probation & parole.

Improve client living situations

Clients of CCS's have the right to live in the least restrictive setting that is appropriate for them. If a client believes that he or she has been placed in a setting that is more restrictive than necessary, they have the right

to legal intervention to determine the appropriateness of the setting that they reside in.

Accomplish targeted short and long term goals

The accomplishment of targeted goals is a method by which treatment progress can be assessed. The Department of Health and Social Services requires that treatment goals be specified along with service actions necessary to accomplish these goals. The Department of Health and Social Services also requires that the goals be developed with both short and long range expectations and shall be written in measurable terms.

All five of the programs in this study included the accomplishment of targeted goals as an aspect to evaluate in their plans.

Summary

The literature reviewed, along with information obtained from the programs contacted, supports the philosophy of this study. Each evaluation plan that was reviewed was unique, consisting of different evaluation criteria for data collection. The evaluation plan developed as a result of this study combined aspects from various plans examined during this study.

Chapter V

DISCUSSION, SUMMARY AND CONCLUSIONS

The purpose of this study was to explore emerging ideas and practices about evaluating community based mental health programs certified by the Wisconsin Department of Health and Social Services. The objectives of this study were to review literature for pertinent information about the evaluation of community support programs; to contact certified community based mental health programs, in order to obtain the evaluation plans used by their programs; to examine the evaluation plans received and discover uniqueness, similarities and differences; and to develop an evaluation plan that could become integrated into the comprehensive community services program located in Marathon County, Wisconsin.

The first objective of this study was to review available literature regarding the evaluation of CSP's. After obtaining and reviewing the literature it became apparent that funding for mental health services continues to be an issue of contention. The development of new and enhancement of current services will be a difficult challenge for mental health programs to face, given such financial

limitations.

The second objective of this study was to contact selected certified programs to obtain the evaluation plans used by their programs. After contacting the program directors, they were all agreeable to participate in the study, although plans from two of the programs were never received.

Objective three of this study was to examine the plans received for uniqueness, similarities and differences. The plans examined held all of the mentioned aspects. Every community support program is unique given staff characteristics, client characteristics, location and funding issues, therefore, it is reasonable for each programs evaluation plan to be unique. The plans contained differences as well as similarities. The one similarity noted across the plans, is tracking the attainment of treatment plan goals as established in each individual treatment plan as an aspect of care. The plan which stood out as the most different was Marathon Counties, in that it covered such a vast array of variables to evaluate.

The aspect of care that all of the CSP's investigated was that of meeting treatment plan goals, as stated on each client's individual treatment plan.

The final objective of this study was to develop an evaluation plan that could become integrated into the CCS located in Marathon County, Wisconsin. Seven aspects of care were selected for data collection in the plan developed as a result of this study. These aspects were chosen as they are high volume, high risk or problem prone areas for the clients located in Marathon County.

The evaluation plan developed as a result of this study is not intended to be a fixed document. This plan should be modified regularly according to evaluation results and client characteristics. New aspects of care should be identified based on current circumstances.

Jerrell (1986), speculated that funding shifts in the nation's mental health system would negatively influence program evaluation services in the area of community mental health. An assumption of this study was, that without high quality monitoring, community support programs are at risk of a reduction in state and federal funding. This was the case in 1986, as noted by Jerrell, and continues to be true today.

The second assumption of this study was that CSP's vary in the amount and types of services. This assumption was substantiated throughout the literature and throughout the evaluation plans examined for this study. Dowell & Ciarlo

(1983), indicate that available community resources and staff to client ratio are typical indicators of what type of services will be offered.

THE LIMITATIONS

The following limitations were placed on this study:

1. The study is limited to Marathon County's Mental Health Outreach Program, in specific, and can be generalized only to other programs in which the context is similar.
2. The data from client evaluations of the Marathon County Mental Health Outreach Program may be biased, in that, they are delivered by, and often assisted in completion by their case manager.

Recommendations

It is recommended that future research investigates other significant processes that characterize the CCS's that are not investigated in this research. For example, how flexible the daily structure of program services are followed, staff cohesion and morale, and the quality of interaction between staff and clients. Focusing on these descriptive indices will give a more holistic picture of comprehensive community service programs.

In addition, research should examine whether programs are following the conceptual framework on which they are

based. The replication of CCS's will be accomplished once the ability to effectively monitor and evaluate programs has been achieved.

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Appendices

Appendix A

CSP Coordinators List

Adams County
Dale Kolstad, Coordinator
Community Support Program
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Linda Ready, Clinical Coordinator
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Buffalo County
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Buffalo County Human Services Dept.
Courthouse Annex
Alma, WI 54610
(608) 685-4412

Community Treatment Alternatives
Linda Keys, CSP Director
David DeLap, Clinical Coordinator
124 W. Mifflin Street
Madison, WI 53703
(608) 255-7586

Program of Assertive Community Treatment
William Knoedler, M.D., CSP Director
Jana Frey, Clinical Coordinator
108 S. Webster
Madison, WI 53703
(608) 266-0721

Gateway CSP
Linda Keys, CSP Director
Jackie Shivers & Mark Taylor,Clinical Coords.
600 Williamson Street
Madison, WI 53703
(608) 251-6137

Dodge County
Mary Wollenburg
CSP Services
199 Home Road
Juneau, WI 53039
(414) 386-3500

Door County
Ted Bauch, Clinical Coordinator
Door County Unified Board
421 Nebraska Street
Sturgeon Bay, WI 54235
(414) 746-2345

Dane County
Linda Keys, CSP Director
Ed Stoll & Karen Pluim, Clinical Coord.
Dane Co. Mobile Community Treat.
625 W. Washington Ave.
Madison, WI 53703
(608) 251-7916

Douglas County
Steve Engleson
CSP Director/Clinical Coordinator
39 North 25th Street East
Superior, WI 54880
(715) 392-8216

Dunn County
Mary Larsen, Program Director
Kathleen Moses, Clinical Coord.
Dunn County Courthouse Annex
808 Main Street
Menomonie, WI 54751
(715) 232-1116

Eau Claire County
Kevin Mannel, Program Director
Tom Wirth & David Hensley
Clinical Coordinators
202 Eau Claire Street
P.O. Box 840
Eau Claire, WI 54702
(715)833-3308

Fond du Lac County
Mary Ellen McMeen
Social Rehab. Program
459 East First Street
Fond du Lac, WI 54935
(414) 929-3565

Florence County
Robert Macaux
Florence County Courthouse
Human Services Dept.
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Florence, WI 54121
(715) 528-3296

Forest/Oneida/Vilas County
Nancy Schneider
Case Management and Supportive Care Prog.
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Rhinelander, WI 54501
(715) 369-2215

CSP for Young Adults
Dennis Nelson
705 E. Timber
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Rhinelander, WI 54501
(715) 369-2215

Grant/Iowa County
Diane Schmidt, CSP Director
Clemens Schmidt, CSP Director
Community Support Program
P.O. Box 351
Lancaster, WI 53813
(608) 723-7666

Green County
Lynette Studer
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Pleasant View Annex, Box 11
Monroe, WI 53566
(608) 328-9393

Green Lake County
Nancy Baker, CSP Director/Clinical Coord.
Green Lake Unified Board Services
Human Service Center
500 Lake Steel Street
(414)294-4088

La Crosse County
Carol Schilling
CSP Director/Clinical Coordinator
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La Crosse, WI 54601
(608) 785-6100

Iron County
Karen Hubel, Coordinator
Iron County, CSP
c/o Highline Corporation
P.O. Box 218
Hurley, WI 54534

Jackson County
Esther Hinshaw, CSP Director
Donnalee Hoelzen, Clinical Coord.
Psychiatric Counseling Services
P.O. Box 271
Black River Falls, WI 54615
(715) 284-9477

Jefferson County
Chris Severson
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P.O. Box 375
Jefferson, WI 53549
(414) 674-3105

Juneau County
Steve Ruff, CSP Director
Amy Burdick, Clinical Coordinator
Juneau County Human Services CSP
220 E. LaCrosse
Mauston, WI 53948
(608) 847-9400

Kenosha County
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815 57th Street, P.O. Box 35
Kenosha, WI 53140
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Kewaunee County
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Kewaunee County Unified Board
522 Fourth Street
Algoma, WI 54201
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Lafayette County
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700 North Main Street
Darlington, WI 53530
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Langlade County
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Langlade County CSP
1225 Langlade
Antigo, WI 54409
(715)623-2394

Lincoln County
Ann Wanserski, Clinical Coordinator
Linclon County CSP
503 S. Center Street
Merrill, WI 54452
(715)536-9482

Marathon County
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Jerry Vedra, Clinical Coordinator
North Central Health Care Facilities
1100 Lake View Drive
Wausau, WI 54401
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Milwaukee County
Michelle Lameka, CSP Liaison
Milwaukee County Combined Community Services Board
235 West Galena Street
Milwaukee, WI 53212
(414) 289-6660

Manitowoc County
Jeff Jenswald, Coordinator
CSP Services
Manitowoc County Human Services
926 So. 8th St., P.O. Box 1177
Manitowoc, WI 54221-1177
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Marinette County
Robin Elsner, CSP Director & Clinical Coordinator
CSP Services
400 Wells Street
Marinette, WI 54143
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Marquette County
Pam Crawford
CSP Director/Clinical Coordinator
Community Support Program
Marquette Guidance Center
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Westfield, WI 53964
(608) 296-2139

Menominee County
Tom Boelter, CSP Coordinator
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Keshena, WI 54135
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Monore County
Gary Nelson, CSP Director
Sue Rettler, Clinical Coordinator
Monroe County Dept. of Human Services
Community Services Building
Route 2, County Trunk B
Sparta, WI 54656
(608) 269-8600

Oconto County
Dawn Pabich
Oconto Co. Unified Health
835 South Main Street
P.O. Box 40
Oconto Falls, WI 54154
(414) 834-7000

Outagamie County
Carol Thomas, Director
Tom Cody, Clinical Coordinator
Human Services Clinic and CSP
3365 West Brewster Street
Appleton, WI 54914
(414) 832-5270

Ozaukee County
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Community Support Program
121 West Main Street
Port Washington, WI 53074
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Pepin County
Steve Peinovich
CSP Coordinator
550 7th Avenue West
Durand, WI 54736
(715) 672-8941

Peirce County
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103 N. Chestnut Street
Ellsworth, WI 54011
(715) 272-4022

Portage County
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Community Support Program
817 Whiting Avenue
Stevens Point, WI 54481
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Richland County
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Stephanie Karwacki, Clinical Coord.
Richland County
1000 Hwy. 14 West
Richland Center, WI 53581
(608) 647-53581

Rock County
Beloit CSP
Erin Lenar, Clinical Coordinator
504 W. Grand Avenue
Beloit, WI 53511-6165
(608) 364-2140

Janesville CSP
Erin Lenar, Clinical Coordinator 35 South Main St.
Janesville, WI 53545
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Sauk County
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Reedsburg, WI 53959
(608) 524-4391

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Carpe Diem CSP
Community Support Program
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Hayward, WI 54843
(715) 634-5997

Shawano County
Ann Jardine, Director
Community Services Manager
311 North Main Street
Shawano, WI 54166
(715) 526-5546

Price County
Dan Horgan, CSP Director
Pam Olson, Clinical Coordinator
Counseling Center
171 Chestnut Street
Phillips, WI 54555
(715) 339-3048

Sheboygan County
Mary Frances Kohl, Coordinator
Eric Brunnich, Clinical Coordinator
1011 North 8th Street
Sheboygan, WI 53081
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St. Croix County
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1246 185th Ave.
New Richmond, WI 54017-6004
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Community Support Program
219 South Wisconsin Avenue
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Trempealeau County
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Franciscan Behavioral Health CSP
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Arcadia, WI 54612
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Viroqua, WI 54665
(608) 637-7052

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Waupaca, WI 54981-2080
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Wautoma, WI 54982
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Oshkosh, WI 54903
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(414) 729-4817

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CSP Coordinator
Community Treatment Team
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Wood County Dept. of Unified Services
2611 - 12th Street South
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Wisconsin Rapids, WI 54494-0729
(715) 421-0880

Appendix B

CSP POLICY: PROGRAM EVALUATION

The Community Support Program's primary objective is to assist clients who have serious and persistent mental illness in advancing their quality of life. This is accomplished through providing quality outreach treatment services of a supportive and rehabilitative nature. A strong emphasis is placed on assisting clients in attaining a level of stability that allows them to reside in the community and outside of hospitals and institutions. In addition, efforts are made to rehabilitate clients in as many areas of life as are needed, feasible, and within the scope of the resources available within the CSP. The client, and where feasible, the client's family are involved in treatment planning as much as possible.

The specific criteria which serves to indicate the extent to which the program objectives are being accomplished are:

1) Client satisfaction. This is measured through a client satisfaction survey administered to a random selection of CSP clients.

2) Family satisfaction. This is measured through a family satisfaction survey administered to a random selection of CSP clients.

Achievements not related to the CSP's stated objectives: These will be documented on a yearly basis and included in the annual report which is reviewed by the Human Resource Center's Board of Director's.

Methods for assessing the effective utilization of staff and resources toward the attainment of the program objectives shall come from:

1) data obtained from client and family satisfaction surveys.

2) yearly performance evaluations performed by the CSP Clinical Coordinator of all CSP staff.

Evaluation of the appropriateness of admissions to the CSP, length of stay, treatment plans, discharges:

All admissions to the CSP are reviewed by the Clinical Coordinator and psychiatrist to insure that HSS admission criteria has been met. The results of these reviews are documented in the client file (see admission assessment). After admission, clients are reviewed on a six month basis. At this time, the client's progress toward treatment goals is reviewed, as well as any major changes which have occurred (see "Six Month Case Conference/ Treatment Plan Review" form). If the client has not met the discharge criteria as specified by the treatment plan, a new treatment plan is formulated by the case manager and reviewed by the Clinical Coordinator and psychiatrist. All discharges from the CSP are reviewed by the Clinical Coordinator and psychiatrist.

Appendix C

CSP Quality Assurance Plan

I. Responsibility for Quality Assurance Function

The Quality Assurance Committee includes the Clinical Coordinator, acting Clinical Coordinator, Psychiatrist, and clerical assistance from the unit secretary. The committee reviews the Quality Assurance Plan annually.

II. Scope of Care/ Service

The Community Support Program is an out patient program serving clients 18 years of age and older with a serious mental illness. The clients have been diagnosed by a psychiatrist as having a severe mental illness as listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental disorders (DSM-III-R) and meeting HSS 63 (CSP Certification) criteria. Some CSP clients are committed to the 51:42 Board for treatment of their mental illness and a majority of CSP clients are treated with psychotropic medications.

Several services are offered to CSP clients including; assessment, screening, treatment plan development, case management, medication therapy, nursing services, crisis intervention, support to client, family and significant others, resource development, coordination of services with other agencies, training in activities of daily living, vocational rehabilitation, money management.

III. Important Aspects of Care

1. Psychotropic Medications

a. Indicator: Clients will present for IM medications without prompting from staff.

Threshold: 90% compliance.

Measure: Public Health Nurse will log injections, and no shows.

b. Indicator: Clients will be compliant in taking their medications as prescribed by the psychiatrist.

Threshold: 80% compliance.

Measure: CSP staff will document missed medications in case notes and complete data form.

c. Indicator: Less than 5% of CSP clients will be hospitalized in acute psychiatric units with an average stay of 7 days or less.

Threshold: 90% compliance.

Measure: CSP staff will complete data form and Clinical Coordinator documents all hospitalizations.

2. Housing

a. Indicator: 95% of CSP clients will live in the community.

Threshold: 95% compliance.

Measure: CSP staff to complete data form reporting type of community residence.

3. Employment

a. Indicator: 25% of CSP clients are involved in employment; volunteer, renumerative, vocational assessment, job development, work adjustment.

Threshold: 25% compliance.

Measure: CSP staff to complete data form reporting current vocational status.

4. Treatment Plans

The CSP treatment team uses the treatment plan process to organize the client's care.

a. Indicator: The Treatment Plan is completed accurately and is timely.

Threshold: 100% compliance.

Measure: Treatment Plan is completed within one month of a client's admission and every 6 months there after.

Threshold: 100% compliance.

Measure: Treatment Plan is signed and dated by Case Manager, Clinical Coordinator, and Psychiatrist.

Threshold: 100% compliance.

Measure: Treatment Plan addresses psychiatric needs.

Threshold: 100% compliance.

Measure: Treatment Plan will address vocational or daily activity needs.

Threshold: 100% compliance.

Measure: Treatment Plan goals are individualized and measurable.

QUALITY ASSURANCE PLAN FOR MONITORING & EVALUATING PSYCHOTROPIC MEDICATION PRESCRIPTION

GREEN COUNTY CSP

Person Responsible: William Knoedler, M.D.
Green County Community Nurses

1. Scope of Care/Service: The treatment and management of major mental illness of CSP clients and the prevention of recurrence of such symptoms, including the use appropriate of psychotropic medication. These medications will be prescribed by the CSP physician, administered and record kept by the Green County Nurses, and distributed to patients by a variety of CSP staff. Dr. Knoedler along with the rest of the staff will assess the theraptuic as well as side effects of these medications and provide education to patients regarding their benefits and risks.

Aspects of Care:
A. Psychotropic medication administration.
B. Assessment of side effects of psychotropic medication.

Indicators	Thresholds	Data Source	Person Responsible for Data Collection	Sampling	Frequency
A1. Patients receiving long-term injectable antipsychotic medications (fluphenazine decanoate and haloperidol decanoate) will receive scheduled injections within 3 days of the day they are due.	90%	Patient record (medication administration record).	Green County Nurse or designee. .	Complete sample of injections of the previous calendar month	Quarterly (March, June, September, December)
A2. Patients under daily mediation supervision will take medications each day they are prescribed.	90%	Same as above.	Same as above.	Complete sample of supervised daily medication dosages.	Same as above.

Indicators

A3. Patients receiving Clozapine treatment will not have interruptions in therapy because of failure to comply with weekly laboratory (CBC) testing.	75%	Same as above (Medication administration record).	Case Manager or other CSP staff	All cases of Clozapine treatment.	Same as above.
A4. Patients receiving treatment with Clozapine will have vital signs assessed every week for the first month they are on Clozapine in the community and at least every month thereafter.	90%	Patient record (vital sign graph)	Case Manager and Green Co. Nurse	Same as above	Same as above

DATA GATHERING FORM FOR CSP PROGRAM EVALUATION

Client Name: _____

Date: _____

1. Was the client hospitalized (short-term acute inpatient) during the last six months?

   Y N # of Hospitalizations _____
   Total # of Hospital days? _____

2. Has the client been institutionalized (Winnebago - Mendota) in the last six months?

   Y N # of Hospitalizations _____
   Total # of Hospital days? _____

3. What setting does this client live in? (Based on the majority of time in the last six months)

   _____ Institution
   _____ Independent Apartment/House
   _____ Adult Foster Home
   _____ Community Based Residential Facility
   _____ With Friends or Family

4. What is the client's current vocational status?

   _____ Competitive Employment
   _____ Supported Employment
   _____ Facility Based Employment
   _____ Volunteer Work
   _____ Vocational Assessment
   _____ Job Development
   _____ Employment not feasible (However, still a written objective on the treatment plan)
   _____ Searching for Employment

5. How compliant is the client in taking their medications?

   _____ Compliant
   _____ Usually Compliant
   _____ Non-Compliant

   Is this person receiving medication management services? Y N

Appendix D

I. Discussion of the 4 components:
   Program
   Client
   Family
   Community Acceptance

II. Monitoring Tool:
   Form I - Individual Client
   Form II - Treatment Data
   Form III - Program Data

III. Quality Review

IV. Annual Review

V. Surveys

PROGRAM GOAL

To develop an intensive care and treatment program which provides a range of treatment, rehabilitation, and support services in the community for persons with chronic mental illness.

PROGRAM OBJECTIVES

1. To identify those clients whose mental illness is severe in degree and persistent in duration, who are at risk for further episodes, and acute disruptions in the community, and have demonstrated a diminished level of functioning in the activities of daily living, which without intensive support will not regain stable adjustment and independent function in the community.

2. To ensure upon admission to the CSP the assessment and treatment plan is coordinated with the client, and a multi-disciplinary team to focus on the unmet needs in the areas of treatment, rehabilitation and support services.

3. To provide each client with a designated case manager who will be responsible for maintaining a clinical treatment relationship and coordinate support services on an ongoing basis.

4. To provide each client with a 24-hour case management response/crisis intervention service 7 days a week.

5. To ensure psychiatric treatment is individualized after diagnostic and evaluative services are completed and carried out with provision for therapy, symptom monitoring, medication services, and referral for medical concerns by appropriate professional staff.

6. To define "small steps" as possible achievable goals in the areas of psycho~~logy~~ - social treatment. Positive goal attainment in small pieces assists the eradication of negative ~~goal~~ symptoms.

7. To adapt the rehabilitation model as the apex of change, which includes accepting some loss of function but striving for compensatory means to save further loss and restoring to a higher level of function, so they can be successful and satisfied in their environment.

8. To meet, treat, work, play and negotiate (advocate) with/for the client in the community while continually advocating for community acceptance.

9. To reinforce the values of the CSP team, recognizing each member for the area of expertise and unique contributions in supporting the work to be done, by daily team meetings, smaller unit meetings, regular training, consultation and supervision.

10. To protect the client's rights.

11. To educate the client, guardian, family, agencies and community resources about mental illness with the emphasis on maximizing functioning and pleasure and to minimize dysfunction and distress.

12. To state discharge criteria for individual clients following the discharge policy/procedure in a responsible manner.

13. To evaluate the program's effectiveness.

KL:cp

PROGRAM EVALUATION:

Basic Question - Is the program functioning as we intended?

1. Have we identified the people who need/qualify for intensive services?

2. Is the treatment plan serving us well in directing treatment, support, rehabilitation, and does it serve as an evaluation for the case manager, the program and the client? Are goals being reached? Are they achievable?

3. Do we have a rehabilitation component - is it working?

4. Are all case managers - managing? Do the clients know who their case managers are? Does the family know? Are their service needs identified but unmet and why?

5. Are response requests and crises being responded to? (This should be demonstrated in the number of hospital admissions and circumstances for admission.) The quality assurance should present the number of sentinel events.

6. Is the Psychiatric Treatment meeting the quality assurance requirements for Clozaril monitoring, medication compliance, AIMS monitoring, Lithium lab monitoring, follow through with medication clinic, and medication education?

7. Community acceptance - identified areas for outreach? Are there a number of legal altercations we should be paying attention to? Is there feedback from the consumer groups and how are we doing?

8. Clients' Rights - Is there a current rights form on each medical record? Are issues of concern brought to the program director and forwarded in the organizational levels?

9. Review staff stability, turnover rate, staff morale, and a review of staff utilization per data printouts and productivity stats.

Format:

Each of these questions will be responded to in narrative for, supplemented with statistical figures as warranted.

Client Evaluation:

Basic Question - Are clients functioning better than they could be expected to without these intensive services?

Areas to Track:

1. Inpatient admissions, the number and length of stay. How many admissions were adverted due to crisis intervention services?

2. Symptom Management - BPRS, LOF, GAF

3. Unemployed to the number who have volunteer work, supportive work, competitive work or are in school.

4. Social Functioning

   a. Friends?

   b. One activity, twice a month with someone other than family or staff?

5. Medication Compliance - Does medication monitoring and medication drop-off make a difference on the client's mental status and level of functioning?

6. The number of AODA admissions.

7. Legal altercations within the community.

Treatment Plans:

Are the treatment plans a "working document"?

1. Response to services provided? Is there follow through? Are goals being achieved?

2. Are we prioritizing the needs correctly? (Are the assessments: General, ADL and Voc. Rehab. purposeful?) Should we be using a Readiness Scale?

Format:

Data: Admissions, length of stay, LOF, GAF, BPRS Ratings

Logs: Crisis Intervention Review, AODA admissions, legal involvement, work activity, looking at work records, % of time worked and earnings.

Case Management Survey: Perspectives of service provisions, which is a form that can be developed and used in connection with each treatment plan review.

Client Satisfaction Survey: (Form to be developed.)

Under Consideration: The Quality Life Questionnaire

Family Evaluation:

Basic Questions - Are we lifting the burden experienced by families?

The areas to evaluate:

1. Are we shifting focal and major problems to the staff and encouraging improvement in the quality of the time the family spend with the client? (Is there less negative affect, berating, less personalized complaints.)

2. Is there increased tolerance ~~and~~ FOR deviant behavior?

3. Are the families noticing less symptoms? Is there a better relationship?

Format:

1. A Family Survey to be done yearly.

2. A Case Manager Survey done yearly.

3. Assessing family education efforts and ranking the understanding and employment of learning. (This is an item that could be coordinated with the patient educator in the form of a pre-post test for educational series.)

Community Acceptance Evaluation:

Basic Question - Are there community needs that require more focus?

1. Identify major areas that cause conflict between the client with mental illness and the community, i.e., housing, quality and availability, and safety.

2. Is the client able to negotiate in the community? For example, as using the banks, the library, shopping.

3. Do ~~are~~ our clients still stand out in a crowd?

Consult/Educate:

1. Speak to civic groups.

2. Speak to individuals - residential/shopkeepers/employers/churches.

3. Increase volunteer recruitment. (For example, the clients volunteering to work in the community has already proved to be an effective means of changing attitudes.)

4. Are there agencies?

5. Support AMI and consumer groups.

Interactive:

1. Are these four areas of evaluation interacting with each other?

NORTH CENTRAL HEALTH CARE FACILITIES
COMMUNITY SUPPORT PROGRAM EVALUATION

FORM 1
PAGE 1

CLIENT # _____ DATE _____ REVIEWED BY _____

CRITERIA	YES NO	COMMENTS
QUALIFY FOR CSP SERVICES		
ASSESSMENT ADDRESSES REHABILITATION COMPONENT SERVICE NEEDS IDENTIFIED/PRIORITIZED		
TREATMENT PLAN DIRECTS TREATMENT SUPPORTIVE INTERVENTION GOALS ACHIEVABLE SHORT TERM GOALS MET WITHIN 1-3 MOS LONG TERM GOALS MET WITHIN 6 MOS		
CLIENTS IDENTIFY WHO IS CASE MANAGER FAMILY IDENTIFY WHO IS CASE MANAGER		
CRISIS RESPONDED TO APPROPRIATELY (VISIT, PHONE CALL, ADMISSION)		
GAF COMPLETED WITHIN 6 MOS?		
CURRENT BPRS IMPROVED FROM LAST BPRS		
MEDICATION COMPLIANT FOLLOWING RECOMMENDED MED. PROGRAM PER TP		
ATTENDED MED CLINIC AS SCHEDULED		
MEDICATION EDUCATION OFFERED/PROVIDED		
AIMS MONITORING COMPLETED		
LITHIUM LAB MONITORING COMPLETED		
CLOZARIL MONITORING COMPLETED		
CURRENT RIGHTS FORM ON RECORD		
SOCIAL FUNCTIONING FRIEND/ACQUAINTANCE IDENTIFIED ONE ACTIVITY 2X/MONTH WITH SOMEONE OTHER THAN STAFF/FAMILY		
ADMITTED SINCE 11/92 PSYCH AODA DUAL ATTEMPT MADE TO DIVERT ADMISSION?		

INDIVIDUAL CLIENT DATA

HOSPITAL LENGTH OF STAY		
..STITUTION ADMISSION SINCE 11/92 PSYCH AODA DUAL		
INSTITUTION LENGTH OF STAY		
LIVING ARRANGEMENT INDEPENDENT ADULT FOSTER HOME CBRF FAMILY/FRIENDS OUT OF COUNTY PLACEMENT		
EMPLOYMENT COMPETITIVELY EMPLOYED SUPPORTED WORK FACILITY BASED WORK PROGRAM WORKSHOP VOLUNTEER HOMEMAKER JOB ASSESSMENT/DEVELOPMENT		
INDEPENDENT HOMEMAKING SKILLS		
INDEPENDENT SELF CARE		
:GAL STATUS PROBATION COMMITMENT PROTECTIVELY PLACED VOLUNTARY		

INDICATOR	CRITERIA	HOW MONITORED
CSP PROGRAM COMPONENTS	PROGRAM COMPONENTS WILL MEET SPECIFIC % AS IDENTIFIED IN PLAN	5 CHARTS TO BE REVIEWED MONTHLY FOR PROGRAM COMPONENTS. ALL RESULTS TO BE COMPILED QUARTERLY AND SHARED WITH PROGRAM DIRECTOR; CLINICAL COORDINATOR; PROGRAM PSYCHIATRIST AND QM DEPARTMENT

Appendix E

Objective I

To reduce the frequency of hospitalizations for acute and chronic psychiatric symptoms by providing CSP services to CMI clients, thereby, reducing impairments in role functions.

Less than 15% of CSP clients will be hospitalized in acute psychiatric units with an average stay of 7 days or less.		Reviewed	Reviewed	Reviewed	Reviewed
	YTD				
	# of hosp admissions	%	%	%	%
	Total # of days				

Objective II

To maintain CSP clients in their least restrictive environment.

90% of CMI clients will be maintained in their least restrictive setting.	Reviewed	Reviewed	Reviewed	Reviewed
1) 96% live independently # 24				
2) 4% live in AFH #AFH 1				
3) 0% live in CBRF #CBRF 0				
4) 0% live in family #with family 0				
5) total in community % 96%				

Objective III

To involve CSP client in employment opportunities that either assist in maintaining employment or assist in job assessment and development.

36% of CMI clients are involved in employment opportunities that include job assessment/job development. CSP will maintain or increase the number of CSP clients involved in employment opportunities.		Reveiwed	Reviewed	Reviewed	Reviewed
# Competitive Employment	4% #1				
# Supported Employment/ Placement	4% #1				
# Sheltered Employment	28% #7				
# Volunteer Work	0%				
Total % Involved in Vocational Activities	36%				

Objective IV

To monitor medications to ensure that CSP clients are compliant with medications prescribed.

80% of CMI clients will be compliant with taking their medications as prescribed.	Reviewed	Reviewed	Reviewed	Reviewed
# Compliant				
# Usually Compliant				
# Non-Compliant				

Objective V

To increase the CSP clients' independence in performing homemaking skills such as meal preparation, laundry, money management, and personal shopping.

50% of CSP client living in the community will be independent in homemaking skills such as meal preparation, laundry, money management, and personal shopping.	Reviewed	Reviewed	Reviewed	Reviewed
# and % independent in homemaking skills	%	%	%	%

Objective VI

To maintain or reduce the number of CSP clients under legal constraints which include Chapter 51, Chapter 55 (guardianship), and Probation and Parole.

Less than 25% of CSP clients are under legal constraints	Reviewed	Reviewed	Reviewed	Reviewed
# Chapter 51 # 12%				
# Chapter 55 Protective Placement # 8%				
# Probation/Parole # 0%				
# Guardianships # 4%				

Objective VII

To meet treatment plan goals as described in treatment plan by coordinating plans and interventions that will allow the best opportunity for success.

25% of short term goals will be within three months of treatment plan.	Reviewed	Reviewed	Reviewed	Reviewed
Total # of goals				
Total # of goals achieved				

25% of long term goals will be met within 6 months of treatment plan.	Reviewed	Reviewed	Reviewed	Reviewed
Total # of goals				
Total # of goals achieved				

DATA GATHERING FORM FOR CSP EVALUATION

(Completed at time of 6 month review)

Client Name _____

Date _____

1) Was the client hospitalized during the past six months?

YES # of hospitalizations _____ # of hospitalization days _____
NO

2) What is present living arrangement of this client?

_____ Lives independently

_____ AFH

_____ CBRF

_____ With Family

_____ Institution

3) What is this client's vocational status?

_____ Competitive Employment

_____ Supported Employment/Job Assessment/Development

_____ Sheltered Employment Setting

_____ Volunteer

_____ Unemployed/or Employment not feasible at this time

4) How compliant is this client in taking their medications?

_____ Compliant

_____Usually Compliant

_____ Non-compliant

Is this client receiving medication monitoring?

YES _____ NO _____

5) Is this client independent in the following homemaking tasks?

Meal preparation	Y	N	Comments
Laundry	Y	N	Comments
Money Management	Y	N	Comments
Personal Shopping	Y	N	Comments
House Cleaning	Y	N	Comments

6) Is this client under any of the following legal contracts?

Chapter 51	_____	Comments
Chapter 55	_____	Comments
Guardianship	_____	Comments
Probation/Parole	_____	Comments

7) Has this client met his/her short term and long term goals for current treatment plan?

Problem 1

Short term goal	Y	N
Long term goal	Y	N

Problem 2

Short term goal	Y	N
Long term goal	Y	N

Problem 3

Short term goal	Y	N
Long term goal	Y	N

DATA GATHERING FORM FOR CSP EVALUATION

(Completed at time of 6 month review)

Client Name _____

Date _____

1) Was the client hospitalized during the past six months?

YES # of hospitalizations _____ # of hospitalization days _____
NO

2) What is present living arrangement of this client?

_____ Lives independently

_____ AFH

_____ CBRF

_____ With Family

_____ Institution

3) What is this client's vocational status?

_____ Competitive Employment

_____ Supported Employment/Job Assessment/Development

_____ Sheltered Employment Setting

_____ Volunteer

_____ Unemployed/or Employment not feasible at this time

4) How compliant is this client in taking their medications?

_____ Compliant

_____Usually Compliant

_____ Non-compliant

Is this client receiving medication monitoring?

YES _____ NO _____

5) Is this client independent in the following homemaking tasks?

Meal preparation	Y	N	Comments
Laundry	Y	N	Comments
Money Management	Y	N	Comments
Personal Shopping	Y	N	Comments
House Cleaning	Y	N	Comments

6) Is this client under any of the following legal contracts?

Chapter 51	_____	Comments
Chapter 55	_____	Comments
Guardianship	_____	Comments
Probation/Parole	_____	Comments

7) Has this client met his/her short term and long term goals for current treatment plan?

Problem 1

Short term goal	Y	N
Long term goal	Y	N

Problem 2

Short term goal	Y	N
Long term goal	Y	N

Problem 3

Short term goal	Y	N
Long term goal	Y	N

Appendix F

I. Responsibility for Quality Assurance Function

The Community Support Program Director, Gene McNutt, will report the results of monitoring and evaluation of the Carpe Diem Community Support Program to the Director of the Sawyer County Comprehensive Planning Board, Pete Sanders, twice/yearly in February and August. The monitoring and evaluation findings will be reported by written narrative, forms and logs.

II. Scope of Care

Clients Served

The Carpe Diem Community Support Program provides outpatient mental health services to individuals 18 years of age and older with varied diagnoses of serious mental illnesses. The psychiatrist has diagnosed these individuals as having a severe mental illness as listed in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM IIIR) and meeting HSS 63, (CSP Cirtification) criteria. Clients with a secondary diagnosis of Substance abuse or developmental disabilities are also admitted to the program. In addition to a major mental illness, clients included in the program exhibit functional impairment in the areas of education, employment and homemaking, Social interpersonal or community functioning and self care or independent living. These individuals are at significant risk of either continuing in a pattern of institution-alization or living in a severely dysfunctional way if CSP services are not provided.

Staffing

Program services are available at the Center from 9 am to 5 pm Monday through Friday. A staff person under the Supervision of the Clinical Coordinator provides on-call services from 5 pm to 9 am Monday through Friday, week-ends and holidays.

Program Staff

(1) Registered Nurse (full time) who has responsibility for program management supervises and directs delivery of Client Services and acts as a Case Manager. She also administers psychiatric medication and offers medication education to clients.
(1) Registered Nurse (part-time) who assists with program evaluation and functions as a case manager.
(2) Psychiatrists (part-time) who alternate responsibility for delivery of services to clients and offer supervision of program management.

COMMUNITY SUPPORT PROGRAM

POLICY: PROGRAM EVALUATION

Program Staff (Continued)

(1) Community Support Worker (part-time) with a B.A. degree who functions as a case manager and assists with psychosocial activities.
(1) Community Support Worker (part-time) who develops Supportive Employment opportunities and assists with ADL and psychococial activities. She also co-leads a Dual-Diagnosis group with a Social Worker under contract services to the Sawyer County Comprehensive Planning Board.
(1) Community Support Worker (full-time) who carries out psychosocial activities, job coaching and ADLs in a supportive and teaching role.
(1) Secretary (part-time) who serves as receptionest and is responsible for typing, timekeeping and billing.

Service Description

The Community Support Program addresses both treatment and rehabilitation services. Clients are provided information on symptom management and assessed for appropriate psychotropic medication with instruction on purpose of medications and possible side effects. Both clients and significant others have opportunities for communication and support with Community Support Program staff in order to better cope with client's mental illness.

Rehabilitation services address functional deficits and include accessibility to DVR services for education and Supportive Employment, instruction in daily living skills, recreational opportunities and participation in the Dual Diagnosis group. Support services include provision of health care services, transportation, financial services, living accommodations and legal services.

Service Delivery

Case Managers are assigned a specific group of clients and each client has an assigned Community Support Worker. The Case Manager Coordinates and monitors servoces for each client and acts as an advocate for the client with other agencies. The Case Manager is responsible for coordinating the work of the Community Support Workers in assessing, treatment planning and delivering services to all clients.

COMMUNITY SUPPORT PROGRAM

POLICY: PROGRAM EVALUATION

Aspects of Care

1. Clients will be monitored closely for responsibility of medication compliance as indication of client's recognition of need for medication.
   Threshold:
   75% of all clients receiving injection medications will report for their injections without prompting.
   Measure:
   The CSP R.N. will log client injections and indicate those clients requiring prompting as well as those who fail to show up as requested.

2. Clients tend to be more productive with improved self worth when they are involved in structured activities.
   Threshold:
   50% of all CSP clients will be involved in either volunteer, competitive or supportive employment a minimum of 4 hours/week within 6 months.
   Measure:
   Staff will report work status of each client at weekly staff meetings and log client work activities.

3. Clients need to experience progress towards defined goals in order to have a sense of achievement.
   Threshold:
   90% of all CSP clients will define short and long term goals and 60% of all CSP clients will attain one short term goal within 6 months.
   Measure:
   Case Managers will check with Community Support Workers each month to note clients progress towards short term goals using GAS ratings.

4. CSP clients will be assisted in taking responsibility for their own transportation needs to promote greater community skills.
   Threshold:
   There will be a 20% decrease in client requests for CSP transportation within 6 months.
   Measure:
   All staff will log transportation requests of clients on a daily basis noting type and outcome of requests.

Aspects of Care (Continued)

5. The Case Managers will work with clients, family members and other agencies to complete treatment plans within 30 days of admission to program.
   Threshold:
   100% complition of all treatment plans will occur within 30 days.
   Measure:
   Clinical Coordinator will note number of admissions and number of treatment plans completed every month.

6. Clients will be offered increased opportunities to improve social skills and time management through varied group activities per month.
   Threshold:
   There will be a 20% increase in group activities offered to clients.
   Measure:
   Additional groups will be planned and scheduled monthly. Clinical Coordinator will see that groups are advertised to clients and note client attendance.

7. Clients will be asked to participate in an annual survey evaluating satisfaction with program services.
   Threshold:
   75% of all clients will respond to survey.
   Measure:
   The Clinical Coordinator will collect, measure percentage and evaluate surveys.

COMMUNITY SUPPORT PROGRAM

POLICY: PROGRAM EVALUATION

System of Review

Internal:

Community Support Program staff meet weekly with the Clinical Coordinator to evaluate clients' progress towards goal attainment as well as note behavioral changes and recommend necessary treatment alterations.

The Clinical Coordinator reviews client's records monthly in order to note frequency of client contacts, staff followup on pursuit of goals and number of hospitalizations with length of stay. The Clinical Coordinator together with the Supportive Employment Coordinator review the number of clients engaged in work activities and assess individual work progress.

The Clinical Coordinator and the Program Evaluation Coordinator are responsible for conducting on-going client reviews to evaluate appropriateness of admissions to the program, length of stay, treatment plans and discharge practices.

External:

The Clinical Coordinator submits a monthly report to the Sawyer County Comprehensive Planning Board citing the number of clients served, units of service being provided and the maximum number of clients able to be accepted into the program. The Clinical Coordinator also submits docomentation of case management services with amount of time utilized with each client.

The Director of the Carpe Diem CSP, Inc. meets monthly with the Board of Directors to report any program additions or deletions. An annual report listing statistics related to admissions, discharges and outcomes is submitted to the Carpe Diem CSP Board of Directors as well as to the Sawyer County Comprehensive Planning Board.

Appendix G

Appendix G

Program Evaluation

Purpose

The purpose of Comprehensive Community Services is to provide individualized, effective and easily accessible treatment, rehabilitation and support services in the community for persons with a mental illness in an effort to reduce the disabling effects of the mental illness and promote recovery.

Program Objectives

1. To identify those people with a mental illness, who have demonstrated a diminished level of functioning, which without services would not regain stable adjustment and independent functioning within the community.
2. To reduce the number of hospitalizations and decrease the length of stay for persons with a mental illness.
3. To increase the likelihood that consumers will obtain and/or maintain involvement with therapeutic, rehabilitative, education and recreational services.
4. To increase community involvement of persons with a mental illness.
5. To ensure psychiatric treatment is individualized and evaluative services are completed and carried out with provision for therapy, symptom monitoring, medication monitoring and referrals to other agencies as appropriate.
6. To monitor and advocate for each client in regards to legal issues.
7. To monitor living arrangements and ensure that each client is living in the least

restrictive setting appropriate for them.

8. Reduce the "disabling effects" a person may experience which is related to his/her mental illness, i.e. social isolation, difficulty obtaining and maintaining employment, neglect of personal care, conflicts with family and friends and suicidal tendency.

9. To provide each consumer with a designated case manager who will be responsible for maintaining a clinical treatment relationship and coordinate support services on an ongoing basis.

10. To protect the consumer's rights..

Aspect of Care I

To minimize hospitalizations by frequency and duration.

Indicator I-A: Number of overnights spent in psychiatric hospitalization annually.

Threshold: Clients will spend no more than 5% of the year (18 days) in psychiatric hospitalization.

Clients hospitalized (list below initials of clients who have been hospitalized this review period)	**Total number of overnights spent in the hospital** (list below for each client indicated on left)	**Percentage of time spent in psychiatric hospitalization** (list below for each client indicated on left)
Total:	**Total:**	**Total:**

Indicator I-B: Number of clients hospitalized annually for psychiatric treatment.

Threshold: No more than 25% of clients will be hospitalized during the year.

Total number of clients (include all clients who've been opened to service during)	
Number of clients who have been hospitalized	
Total percentage:	

Aspect of Care II

To increase vocational services and employment.

Indicator 2: Number of clients under the age of 55 who are involved in employment.

Threshold: 40% of clients under the age of 55 will be involved in full, part-time, volunteer work or pursuing educational goals, defined as working 20 or more hours per month in competitive (i.e., earning minimum wage or above), supported work (i.e., earning less than minimum wage), volunteer work or attending school.

Number of clients under the age of 55.	
Number of clients working or attending school based on the above criteria.	
Total percentage:	

Aspect of Care III

To monitor the locus of service delivery.

Indicator 3: Amount of time with client which occurs within the community.

Threshold: 50% of the time spent in client contact will occur in the community as opposed to in the office.

Total client time (in hours)	
Amount of time with client occurring in the community (in hours)	
Total percentage:	

Aspect of Care IV

To monitor medication compliance.

Indicator 4: Number of clients who are compliant with taking medications as prescribed.

Threshold: 80% of clients will be compliant with taking their medications as prescribed.

Total number of clients who were complaint in taking their medications during this review period.	
Total number of clients who were not complaint in taking their medications during this review period.	
Total number of clients being assessed. (Add clients who were compliant with medications to those who were not complaint)	
Total percentage of clients who were compliant with taking their medications during this review period. (Use total number of clients on case load to get this figure)	

Aspect of Care V

To minimize legal constraints.

Indicator 5: Number of clients under legal constraints.

Threshold: Less than 25% of clients will be under legal constraints which include; mental health commitments, guardianships, protective placements and probation & parole.

Number of clients under mental health commitments.	
Number of clients under protective placement.	
Number of clients under guardianship.	
Number of clients under probation & parole.	
Total number of clients under legal constraints.	
Percentage of clients under legal constraints (Total number of all clients on case load should be considered when establishing this figure)	

Aspect of Care VI

To improve client living situations.

Indicator 6: Clients will be placed in the least restrictive living situation possible.

Threshold: During four clients will advance to more independent living situations.

Living Arrangements	**Number of clients receiving services this review period in this living arrangement**	**Number of clients who moved out of this arrangement into a less restrictive setting.**
Long-Term Psychiatric facility		
Adult Family Care Home, Community Based Residential Facility.		
Supervised Apartment		
With Family		
Independent		
Totals:		

Aspect of Care VII

To Accomplish targeted short and long term treatment goals as identified in each clients individual treatment plan.

Indicator 7: Percentage of both short and long term goals accomplished in the period between treatment plan reviews, (average of six months).

Threshold: 50% of all short-term goals and 25% of all long term goals will be met during the period between treatment plan reviews.

Total number of short-term goals due for review:	
Total number of short-term goals met:	
Percentage of goals met:	

Total number of long-term goals due for review:	
Total number of long-term goals met:	
Percentage of goals met:	